GMC response to the Department for Education consultation on Information sharing advice for safeguarding practitioners.

Questions from the consultation

1. **To help us analyse our responses, could you please tell us what type of agency/organisation your work for?**
2. **What is your role within your agency/organisation?**
3. **If you are responding on behalf or your agency/organisation, please provide the name below:**
4. **In sharing findings from this consultation, may we quote from your response? [NB there is no question 5]**

6. To what extent do you agree that the Seven Golden Rules are a helpful guide to enable practitioners to share information appropriately?

It is difficult to reach a view on this question, given the many different sectors, types of organisations, and range of roles and responsibilities that the Rules would need to support. Our response focuses on doctors and their professional responsibilities around child safeguarding and child protection. We believe that, as drafted, the golden rules would not be helpful to doctors, as they do not encompass key legal and ethical duties which doctors must take into account, in deciding whether to share confidential patient information. In addition, feedback from key stakeholders who have expert knowledge and current experience in child safeguarding and protection, suggests that the golden rules are confusing and will not provide the level of clarity needed to act as a reliable decision-support tool.

7. How could we make the Seven Golden Rules more helpful?

We appreciate that the purpose of the seven golden rules is to provide all practitioners, across all sectors, with a quick and accessible way to start thinking about whether they can and need to share information with appropriate bodies to safeguard children and young people in their care. Perhaps this is why the focus in these golden rules is on the Data Protection Act 2018 (the DPA). Understanding that the DPA applies in all settings (schools, youth groups, care settings, community health services, GP practices, hospitals etc), we know that it can be wrongly seen by some individuals or organisations as a barrier to sharing child protection concerns.

However, the seven golden rules fail to capture the requirements of the common law duty of confidentiality which applies in healthcare, in addition to the DPA requirements. This common law duty must be taken into account by doctors (and other healthcare professionals) when they make decisions about sharing a patient's confidential information. The seven golden rules also do not capture the key professional standards that doctors must take into account, in addition to the legal framework (please see answer 14 for further details on this point). It would be helpful either to expand the golden rules or develop a complementary set of rules specific to healthcare.

8. Is there anything you find unclear or confusing in the Seven Golden Rules?

See our response to Q7.

9. To what extent do you agree that the Information Sharing Advice clarifies how data protection legislation provides a framework for appropriate information sharing to safeguard children?

We would be interested to know the ICO's views on this question. It would be important to have their endorsement of the final content.

We would stress again that, in as far as the information sharing advice solely focuses on the application of data protection legislation, this gives an incomplete picture of the legal duties relating to patient confidentiality that doctors are expected to uphold in the health sector, specifically the common law duty of confidentiality (see answer 14 for further details).

In addition, it isn't made clear that while the DPA sets out the conditions that must be met for a disclosure to be lawful, it does not determine when a disclosure is justified or professionally defensible. The draft guidance suggests that disclosures without consent will be lawful, and can be justified, where there is any concern about a child's welfare or about 'harm' to a child. However, in our understanding of the current legal framework, as supported by the statutory guidance 'Working together to Safeguard Children', child protection action is justified where there is a risk of 'significant harm'. As we have outlined in response to question 14 below, our guidance on Protecting Children and young people reflects that position and makes clear that disclosing information about a child or young person for the purpose of child protection can be done without consent.

If the current legal framework remains the same, then suggesting that disclosures can be made without consent at a lower risk threshold would be misleading for practitioners.

10. To what extent do you agree that the Information Sharing Advice provides reassurance that data protection legislation is not a barrier to information sharing?

11. To what extent do you agree that “consent” is explained in a helpful way?

The concept and importance of consent when considering whether to share information for child safeguarding purposes is not sufficiently explained. This may be because the draft makes no distinction between:

(a) the role that consent plays in ‘child safeguarding’ when practitioners are responding to the broader welfare needs of a child or young person (i.e. putting in place supportive interventions with their and their parent/carer’s agreement), and

(b) the very limited relevance of consent in ‘child protection’ when practitioners are responding to concerns that a child or young person is at risk of or is experiencing significant harm (i.e. taking rapid action to deal with actual or suspected child abuse or neglect).

As we understand the DPA, it is true to say that, if a practitioner intends to share confidential information (including health information) for child protection purposes, it would be inappropriate to seek consent from the child or their parent/carer when a refusal would be overridden. It is therefore helpful to be clear with practitioners that they are not required to obtain consent as their legal basis for sharing information for child protection purposes. However, consent does continue to play an important role in decisions about information sharing for broader child safeguarding purposes, and the approach in this case also set out in our Child protection guidance. It may be helpful to include a clear link to our guidance to ensure that doctors are reminded that this advice is available to them.

12. After reading the Information Sharing Advice, are you confident to share information where a child or young person was at risk or perceived risk of harm without relying on consent as the relevant legal basis?

See our concerns about the risk threshold for sharing confidential patient information, in response to Q9.

13. How could the advice on the legal frameworks and concepts be improved?

It is important that the advice you provide reflects not just the DPA but other key legal frameworks which professionals in different sectors face. For example, in the case of professionals working in health and care, the common law duty of confidentiality applies, as well as the data protection framework. However, it’s also important to be clear about how these frameworks interact with other legal requirements such as, the risk thresholds for action and for sharing confidential information (see our answer to Q9), and professional duties where individuals belong to a regulated profession. You may want to draw on or link to our guidance on Confidentiality, and Protecting children and young people, as both take account of and are consistent with the DPA and common law frameworks.

There may be particular working practices that the guidance could promote, where there is evidence that they facilitate better understanding of the legal framework and more effective information sharing to protect children, for example some multi-disciplinary teamworking arrangements and the multi-agency safeguarding hubs (MASH).

We know that multi-disciplinary working between local community nurses, midwives and health visitors means that they have regular, ongoing relationships with local safeguarding leads and MASH teams; there is easier sharing and triangulation of lower-level concerns; and this helps to create shared views on the thresholds for referring families for safeguarding support or initiating child protection action. Local GPs may not have the same level of interaction with local children and their families or regular interaction with safeguarding staff or the MASH team. In our Child protection guidance, we encourage doctors to actively engage with local family support and child protection services, for example participating in the MASH teams and local safeguarding reviews, to better understand how decisions are made locally and better able to advise children and their parents/carers. You may want to link to or highlight this content.

14. To what extent do you agree that the Information Sharing Advice sufficiently explains to practitioners their information sharing responsibilities?

We understand and are sympathetic to the Department for Education’s aim of providing a framework for practice around information sharing which applies, in the same way, to all those working in education, health, social care, policing and other contexts where child protection concerns may arise. However, the approach taken in the draft suggests that all professionals are under the same set of legal obligations, when it comes to disclosing confidential information about a child. This is not the case. Doctors and other healthcare professionals have a common law duty to protect patient confidentiality. This is in addition to the requirements of the DPA. It is often wrongly assumed that the DPA overrides their common law responsibilities, and this seems to be the case in the draft advice.

We know the DPA is often cited by some professionals as a barrier to them being able to share information with other agencies, as the requirements for lawful disclosure set a high bar. So, we understand why the draft guidance focuses on explaining that the DPA does not require consent to be obtained, in order to share child protection concerns. However, this is not a full account of the position within healthcare.

We are clear that doctors have a common law and an ethical duty to make child protection disclosures (to safeguarding leads, the police, and other agencies) and this can be done without seeking consent. They also have a common law and ethical duty to protect information and seek consent from a parent, or a child or young person who has capacity to make decisions, before making a disclosure for welfare purposes (noting that welfare concerns are part of the wider 'safeguarding' duty).

We see it as a well-established approach in the field of child safeguarding and child protection, to differentiate between actions necessary to tackle sexual abuse, violence against and exploitation of children (child protection), and actions necessary to respond to lower-level wider concerns about a child's welfare (child safeguarding). This is reflected in a range of existing guidance, including the statutory guidance, Working together to Safeguard Children. Child protection action, including appropriate information sharing, does not require consent, whereas providing supportive, preventative interventions needs the consent and cooperation of a child's parents or carers and preferably the child where they have capacity to make their decisions. This approach is reflected in our Child protection guidance.

We note that this approach is also recognised in the final report of the Independent Inquiry into Child Sexual Abuse, at section C paragraphs 6-10. The report distinguishes child protection from safeguarding of children and young people, noting that 'the latter covers a much broader range of activity and extends beyond protection of the individual child to the wider responsibilities across society to ensure that children are safe. Both are important and sometimes overlap.' The Inquiry does not suggest that this distinction needs to change, (although it recommends making disclosure of child protection concerns a statutory requirement on professionals). The draft advice says that it is drawing upon the statutory guidance, Working together, for its definition of safeguarding and promoting the welfare of children, and we think that it should maintain the distinction between safeguarding and child protection to ensure both documents remain consistent for use by frontline practitioners.

We appreciate that the draft advice refers to our guidance on Confidentiality, and Protecting Children and Young People in the introduction. However, we would want the non-statutory guidance to more consistently reflect our guidance on Protecting children and young people, to ensure doctors are clear about the wider duties they have which are not covered in this draft advice.

Importantly, we make clear that doctors are required to make disclosures in the case of child protection concerns, and disclosing information without consent is justified. We also recognise that, in the case of older children and teenagers with capacity, they may want to have some control over the timing and extent of disclosure to children's services, the police and other statutory agencies. In those circumstances our guidance still requires prompt disclosure, but it also allows some scope for doctors to use their judgment about the pace and extent of disclosure to respond to a child's concerns. This scope to exercise judgement within a healthcare context is absent from the non-statutory guidance.

We also say that doctors should support children and their families at an early stage, to get the care and support that they need from local services to help children to thrive, seeking consent from the child or parent as appropriate (see paragraphs 3, 8, 22 and 35). However, the draft non-statutory guidance promotes information sharing without seeking consent, across the range of concerns a professional may have about a child's wellbeing and safety.

As these aspects of the draft non-statutory guidance conflict with our expectations of doctors, it would put them in a very difficult position. Where there is conflict between our guidance and non-statutory guidance, as we say at Q17. above, doctors are most likely to follow the standards set out in our guidance.

We appreciate the reference you have made to our guidance on Protecting children and young people to help explain the perspective within the healthcare sector. However, it is important that the seven golden rules and the guidance as a whole, fully reflects the duties and responsibilities applying to healthcare professionals. We are keen to continue working with you, as we share the same goals around supporting practitioners to have clarity about the decision-making framework and confidence in the actions they need to take, to protect more children from abuse and neglect and improve the support that families and children receive when they are in need. We think there is scope for greater collaboration, across the healthcare regulators and with other healthcare stakeholders such as the medical Royal Colleges, to pool our knowledge and insights to achieve a stronger collective effect in this area of practice.

15. How easily can the Information Sharing Advice be applied to the day-to-day role of practitioners so as to support them to share information appropriately?

16. To what extent do you agree that the Information Sharing Advice supports you to share information to protect children.

17. Does the Information Sharing Advice complement other relevant guidance that applies to your organisation or profession?

In its current form the advice is not consistent with the guidance we provide to doctors on confidentiality and Protecting children and young people. This divergence is likely to cause confusion and concern, as doctors are expected to uphold our guidance on professional standards as a condition of their registration. It's likely that, where non-statutory guidance is inconsistent with the guidance from their regulator, doctors will continue to comply with GMC professional standards (please see our answer to question 14 for further details).

18. To what extent do you agree that the Information Sharing

Advice is user friendly?

19. Is there anything you find unclear or confusing in the Information Sharing Advice?

See our response to Q14.

20. Is there anything missing from the Information Sharing Advice?

See our response to Q14.

We wonder whether it would be more reassuring for practitioners, in terms of encouraging appropriate disclosures and reducing unfounded fears of breaching the DPA, if the ICO were able to publish advice specifically around the relationship between the DPA/GDPR and practitioner duties to act on safeguarding and child protection concerns.

In addition, if the threshold for making disclosures without consent is lowered from a risk of ‘significant harm’ to a child, to a risk of ‘harm’ that includes general welfare concerns, there is potential for a huge increase in the volume and type of information being shared with child safeguarding and child protection services. This might cover not just personal information about the child but also information about a wide range of adults involved in the child’s life. The guidance would need to explain how the DPA applies to sharing this wider information, and how it can be lawfully processed and retained by those receiving the disclosures.

21. Do you have any overall comments about the potential impact, whether positive or negative, of our proposed changes on those who share protected characteristics under the Equality Act 2010? Where you identify any negative impacts, we would also welcome suggestions of how you think these might be mitigated.

We understand that a significant proportion of the families and children who are likely to be in need of support and where children may need child protection intervention will be from disadvantaged groups including groups that share protected characteristics. Therefore, it seems likely that guidance which promotes increased sharing of confidential and sensitive information without consent will disproportionately affect these groups. If this leads to increased interventions in their lives which have not been sought by them, or where they have little say in how matters are handled, this may lead to those who are most in need choosing to disengage from healthcare and other services to avoid scrutiny. This would be counter-productive in terms of ensuring that families in need receive early preventative support and that children at risk are identified sooner and action is taken more swiftly.